

# [The social context of nursing practice essay sample](https://assignbuster.com/the-social-context-of-nursing-practice-essay-sample/)

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This assignment will reflect on a scenario concentrating on ageism and will focus on valuing diversity and anti-discriminative practice. It will discuss how they are important to the delivery of care. I shall also discuss how I have developed and improved my interpersonal skills with both patients and colleagues and overcome barriers created through prejudice and labelling. Also considered is how the Johari window (Luft & Ingham 1955) allows understanding of the self and how that has an important effect on practice.

Using reflective practice I have gained insight into my strengths and weaknesses. Reflection is being able to link theory to practice effectively (Jarmen 1993). I have used my reflective diary to support this assignment.

Diversity is the quality of being different or varied (Smart 2000). Therefore each patient’s needs differ and care must be delivered accordingly to suit the individual’s needs. Diversity is an important part of daily life and is an issue in every workplace and I recognise that it is particularly relevant to the health care profession. Practitioners have a duty to provide appropriate care irrespective of gender, age, race, disability, sexuality, culture or religious beliefs (NMC 2002)

Discrimination is as unfair treatment of a person, racial group, minority based on a prejudice (Smart 2000). It occurs when an individual receives less favourable treatment than others in a similar environment or circumstances on the grounds of disability, gender, class, age, ethnicity, religion, race, soci-economic status or sexual orientation. (JMU equal opportunity policy 2003.) For example someone may think all elderly people are infirm and senile and so when they actually encounter an elderly person they are patronising or rude.

Stereotyping is a standardized image of a type of person (Smart 2000) Everyone stereotypes to a certain extent, we make judgements in our mind which effects interactions. When assumptions are made ie “ All old people lose their memory” it is a major part of discrimination as it is based on prejudice. Prejudice is an opinion formed beforehand, the act or condition of holding such opinions, intolerance or dislike for people of a specific
race, religion or group (Smart 2000.) These are similar and involve labelling individuals or groups, something which can be destructive to providing individualised care. Labelling is the ascribing of a negative label to an action that is then taken as a means of defining a person (Birchenhall 2000).

At the core of every patient nurse relationship is the ability to communicate effectively (Faulkner 1998). There are two main types of communication; intrapersonal and interpersonal (Northouse 1998.) Intrapersonal communication is communicating with ourselves for example keeping a diary. Interpersonal communication is communicating with the outside world ie a nursing assessment. This is an interaction between either two or more people Balzer-Riley (2000). It is an integral component of any relationship. Communication involves how we perceive others, allows us to form stereotypes, impressions, judgements and opinions. So when you discriminate the individual may feel undervalued and have little confidence (Burnard 1997).

Self awareness is a good way to improve our communication skills and our relationships with others. Therefore this is a major part of how others react to you and can say a great deal about you, so if people constantly convey to you that you are stupid, it is hard not to believe them. This belief happens when a person starts to perceive a negative self image. Self-image is defined as ‘ our own assessment of our social worth.’ (Price 1990)

A concept I feel is relevant is known as a self fulfilling phophecy. A self-fulfilling prophecy is a false definition of the situation evoking a new behaviour which makes the originally false conception come true (Merton 2004). It relates to self-image and self-esteem to the extent that our interpersonal communication behaviour is likely to reflect the way we see ourselves. We are also likely to seek from others confirmation that our self-image is accurate. So if we see ourselves as winners, others will and, as a result we may well turn out to be winners; if we see losers then losers we will be.

I will now discuss ageism. As a society we are not very tolerant of the elderly and Yates (1997) poses the question if from the moment we are born the ageing process begins then why should elderly people become devalued because of their age? Biggs (2000) sees ageism as the daftest form of prejudice since we all grow old. We all know ageism exists but what is it? Ageism can be seen as a process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this for skin colour and gender (Butler 1969.) Ageism allows the younger generations to see older people as differently from themselves and is seen as any prejudice or discrimination against or in favour of an age group (Palmore, 1990). Ageism is mainly deemed to be against the older person, but can also affect the younger generation. Ageism is about someone not being recognised for their ability because of their age albeit too young or too old (Palmore 1990)

Thompson (1995) believes that ageism portrays older people as having little worth and as a drain on society. Labels such as ‘ geriatric’, ‘ the elderly’, or ‘ the confused’, are seen to dehumanise older people and undermine their dignity. The promotion of dignity through verbal communication, might convey to patients an acceptance of their values, and in so doing, increase the potential for effective patient nurse interaction.

I believe ageism is rife in the NHS. I know many health care professionals whose attitudes are testament to this. In addition to this in health service debates the elderly are discussed using negative terminology. For example; they are a drain on resources, a burden to health service providers and a high cost user group of health services (Ryan 2000.) I remember a health care assistant telling me that the elderly are only admitted to die or because they are a burden to their family who can not cope. However I have found despite the negativity directed towards the older population and their use of health services statistics show that in the year 2000, in the 65-74 age group, 19% of men and 37% of women lived alone, and 33% of men and 60% of women aged 75 and over lived alone and cared for themselves in their own homes. (www. ageconcern. co. uk) However some elderly people do die in hospitalor are discharged to a new place of care but only in the patient’s  best interests.

Since the National Service Framework (NSW 2001) for older people was published the government recognise that age discrimination is a growing problem that needs much attention. A nurse expressed she was ageist, and that when an older person is admitted she does not see the person; she sees piles of paper work, and too much time wasted on one person when she could be with other patients. I felt very sad on hearing this, as it is my belief that the older patient should be entitled to the same respect and the same care as a younger patient. The older generation makes up about 18% of the population and yet they use 40% of the National Health Services resources (www. ageconcern. co. uk.) Despite this though the majority of health care professionals who work with older people and elderly people are still thought of with a low regard (Ellis 2001). Since the majority of patient’s are over 65 people’s opinions of the elderly is important as the way we think may affect our practice. It was found it takes 10 seconds to judge somebody Pinker (1998).

Age discrimination in UK but often goes unnoticed and unchallenged, even though it is just as wrong as racism and sexism (www. helptheaged. co. uk). Help The aged are urging people to join their campaign to raise awareness and since the publication of the NSW (2001) the Government have stated that ageism exists in the NHS and that they are going to target this problem. However at present there is no existing legislation that protects the older person from discrimination; but the government say by 2006 there will be laws in place to protect people who suffer discrimination because of age.

The Nursing Midwifery Council (2002) highlighted it was placing increased value on the diversity of individuals as employees, professionals and members of society. Nursing is often reported to embrace individualised care through adopting a holistic and patient-centred approach, yet frequently encounters both indirect patient care and underlying attitudes of racism, ageism, and sexism. The Blofield report (2004) suggests institutionalised racism is present in the NHS. This long-awaited report on the death of a black mental health patient at the hands of nurses is only one example that supports the way ethnic minority patients are treated in the NHS. The government has braced itself for criticism as the findings are expected to confirm that the mental health services are beset by institutional racism.

It is widely recognized that we live in a youth-oriented society, where little attention is paid to ageism toward older adults (Blackmore 1998) but my opinion is that older people are of as much value and deserve holistic care, as much as a young person. I feel that age should not be seen as a barrier. A barrier is anything that affects successful communication. Gray (1988) argues that the ageist belief that all older people are unable to change, learn or develop in any way, leads to a more prosthetic approach to service provision. It is also assumed in some areas of health care, that the needs of elderly people are less important than those of the young and that the elderly benefit less from treatment. This has possible ethical implications if care is given or denied on the basis of age.

I do not profess to be perfect but I try to be respectful to patients. Whilst on placement I have to put aside my personal feelings but this is not easy as our attitudes, values and beliefs are acquired we are not born with them (Hindle 2003) These effect the unique way in which I view the world yet in practice I have to accept that a patient is a patient and I should portray a non judgemental approach to a patient regardless of personal beliefs or values. I admit it can be hard not to make judgements. However I am confident in seprating my personal feelings from my professional career.

The scenario that will be discussed is about a patient that I met on a recent clinical placement on a surgical ward. Many of the patient’s on this ward were self caring but there were a few older patients that were in need of assistance.

To maintain confidentiality I will observe the Nursing Midwifery Council’s (NMC 2002) code of conduct. The patient will be referred to as Joan. She is a 77 year old lady, with dementia, is bed bound, and was admitted after a fall at home. She has a past medical history of two cerebral vascular accidents two previous myocardial infarctions, recurrent urinary tract infections and is a type 2 diabetic. Joan was immobile and needed full assistance with all of her daily living activities (Roper, Logan & Tierney 1996.) Joan had a urinary catheter in situ to protect her pressure areas, and is incontinent of faeces. She had no concept of where she was and would often only cry, shout or hit out, therefore patience and understanding from the nurses was required. During handover I was able to gage how the staff reacted to Joan. Using my reflective journal I remember how she was described as ‘ another bed bath’ ‘ a bed-blocker’ and ‘ another old one.’ Admittedly the ward was very busy and heavy. Were these comments because the patient had complex needs or was it ageism?

This scenario comes from a morning shift. I had impression of a difficult, heavy, confused, immobile, aggressive, uncooperative lady. After this representation and others’ comments I was feeling a little apprehensive.

I was asked to bed bath Joan and told someone would join me. I approached Joan and explained who I was and what I wanted to do. I asked permission to remove her clothes however she started shouted and hitting out. The ideas that I previously had seemed to be confirmed and as Henley and Scott (1999) suggest our attitudes are constructed in response to information we receive. I suppose due to my feelings at the time I labelled Joan as a problem.

I moved away to get assistance when two colleagues appeared. I was greeted with ‘ Haven’t you finished yet?’ When I tried to explain one remarked ‘ Surprise, surprised bet this old one wont help.’ I recall being very shocked. After all I would expect if that was my mother lying in that bed she would be treated with respect. When we started washing Joan I remained silent and again she hit out. The others seemed to simply ignore this and discussed trivial matters like having their nails done and holidays. Baltes (1984) states that when staff are engaged in conversation with each other; this appears to be at the expense of interaction between staff and patients. Also unwillingness to communicate can also display a lack of interest towards the patient (Ellis 2001.) This added to my already growing anger towards my colleagues and I began to rethink my opinion of Joan and question myself.

I remember that even when Joan was acknowledged she was resistant to our actions. I think the language the staff used; ‘ come on be a good girl, sent a direct message to Joan that they were not respecting her; they didn’t use her name and spoke to her using childish language. A study by Hewison (1995) found the language that nurses use when communicating with the elderly resulted in them acquiring a certain power over their patient. I found myself empathising with Joan. Empathy is used to describe our ability to place ourselves in other people’s shoes, see the world through their eyes and feel what they feel (Porrit 1992.) I feel that this is a vital skill for nurses to be equipped with. So I tried to considered myself lying there; naked, defenceless, exposed and ignored. When I did this I was on the verge of tears. I put the cot side down, so to break a barrier; and placed a towel over her, to give back what had been taken away. The NMC (2002) support the attainment and preservation of dignity.

I changed my approach; I spoke softly, smiled to display my interest, reassured her we would be finished soon and held her hand to show I cared. Touch is an important aspect of nursing and can be nurturing and friendly (Burnard 1992.) Joan’s eyes softened, she stopped shouting and she smiled at me when I spoke to her. I feel using effective communication skills this helped to build a trusting nurse-patient relationship. By empathising with Joan I started to understand the feelings that she was experiencing (Burnard 1997.)

However this effect was short lived as once Joan was moved she continued shouting, hitting out and being uncooperative. The attitudes’ displayed by my colleagues now showed annoyance when they spoke. Their comments were also now directed specifically at Joan. They advised me not to be nice to her as I was wasting my time. When Joan screamed she was told to shut up and be quiet. I just wished that I was not in there, however my attitude to Joan did not change I maintained eye contact and smiled. Eye contact and facial expressions are important in denoting our thoughts and attitudes and as Hartley (1999) suggests, “ Our communication is the expression of our ideas
and values.”

Unfortunately just as we were finishing Joan had an episode of faecal incontinence. The staff’s responses were again unpleasant. They attended to Joan whilst continuing their conversation and left. I recall just standing alone shocked, disappointed and disheartened. I could not believe what I had seen. Their impersonal approach was rude, disrespectful and uncaring. Although not physically abusive I feel that when you are told something about yourself this tells you this is what you are really like. I couldn’t help but wonder what impression Joan had of herself. I now realise that Joan’s resistance, lack of co-operation and screaming were a barrier to protect herself.

In answer to my question were the staff’s comments because the patient had complex needs or was this ageism? I think it was ageism as Joan was categorised in handover; was spoken to using language that denoted superioty and power (Hewison 1995) and ignored by the staff delivering her care. I feel that this ageist practice must that must be stopped. I still feel angry with my self that I did not do anything to stop it.

Later I recorded my thoughts in my reflective diary. I did this as Johns (1996) identified that the reflection process was concerned with ‘ a dynamic interpersonal caring process’ which enabled the practitioner to ‘ expose, confront and understand contradictions between the way she practices and what is desirable’. He argued that by recognizing the conflict and contradictions in practice, the practitioner would be empowered to take appropriate action to resolve the contradictions. He also states that ‘ failure to work in desired ways is unacceptable to the practitioner committed to caring. This results in anxiety and becomes a focus for the practitioner’s attention. After reflection I felt able to discuss my thoughts with my colleagues as I would have to work with them again. I wanted to know how they could dismiss the patient and treat her with such low regard.

I spoke to my mentor who was shocked that I felt uncomfortable but he explained the staff I was refering to were thought of highly but it was recognised that they expressed opinions when inappropriate and told me not to dwell on it. This was not the response that I had anticipated and so had every intention of asking for an explanation from my colleagues. However the reality was very different; every time I tried to broach the topic I was unable to; they were friendly with each other and I did not feel comfortable questioning them. I felt awkward, and vulnerable as I did not want to be singled out or excluded as I was a student nurse and had been there only a short period. I think If I had been comfortable or in a role of authority I may have spoken up. As a result for the rest of my shift, I tried to see to Joan’s needs. I suppose this was because I felt guilty for letting Joan down first time around. After the scenario I formed a bond with Joan as I saw her as a person instead of a problem.

I found that my positive approach to Joan developed after reflection when I increased my self awareness. Self-awareness is being able to analyse the motives underlying our behaviour (Thrower 1999.) So why do we need to be aware of our-self? Surely we must know what’s going on inside ourselves? But the self is private world; and we need to be comfortable with ourselves before we can understand others. Self-awareness is important in developing whom we are. A model of self that illustrates the importance of self-awareness in the growth of a confident, effective person is the Johari window (Luft and Ingham, 1955). This model is shown to have four quadrants (see appendix.) Using this has been useful; I have identified knowledge of my poor communication and prejudged opinion of Joan. My public pane has increased which is what the johari window aims to do (Thrower 1999) and my blind pane has decreased as I have learnt that I did have prejudice. Through self-disclosure, we open and close panes so that we may become more intimate with others. I am now aware of that my communication skills are still developing, and that I need to be more assertive. Being assertive is important for the sake of those for I am caring for, earns respect from others, increases self-confidence and enables the nurse to be an advocate for the patient, be this in relation to a patient’s direct care or indirectly by challenging working practices.

Unfortunately the areas I have identified are still common place. I know can only make me stronger and will empower me for future interactions. I feel that if I am aware of myself, utilise good communication skills and gain knowledge of others, then I can value people’s diversity and practice in an anti-discriminative manner effectively. I know that working relationships can be one of the greatest stresses for health-care workers, but by caring for one another by being open and respectful, working relationships will be enhanced (Russell 1999) I realised I should have spoken to the others about the incident. Instead I took it upon myself to protect Joan.

I have positive and negative feelings towards the scenario. On the positive side, I realised my prejudice and have corrected it. Before this placement I thought I did not have prejudice and treated everyone equally. I know now that this was not the case. Therefore another positive is that I feel able to except everybody. The negative point is that I prejudged Joan before I met her and did not speak up.

Before this module I had little knowledge of age discrimination and valuing diversity. I did not realise it was so active within the NHS, especially when nurse’s play an enormous part in the lives of those we care for. As a result I have learnt that with an aging society it is important that we do value diversity. I think valuing diversity allows us to understand people’s differences; view a new perspective; to enrich our own lives because every person is unique, not because of ethnicity, age, sex or disability, but because each contribute in a different way.

I believe that I am learning everyday whilst I am a student and will continue to learn when I am qualified. Without these experiences I would be unable to improve my practice, and make a difference to the future of the health service.

I know that valuing diversity must not be overlooked. Nursing is one of many institutes that does not always value diversity, but there are many more but there are many more examples including the police force which has been subject to much media scrutiny.

In conclusion I believe it important that we as health care professionals value the older person and that we should challenge ageism and ageist practice whenever we encounter it.